HOSA-Future Health Professionals
Washington Leadership Academy
Medical Liability Release Form

DIRECTIONS: Due to legal restrictions, it is necessary that **all** delegates, parents/guardians, guests and HOSA Advisors complete this form to be eligible to attend the HOSA Washington Leadership Academy. This form should be submitted to the State Advisor. In turn, the State Advisor will make a copy for his/her files and mail the original forms to HOSA Headquarters.

Delegate Information

Name _____ Date of Birth _____

Cell Phone _____

Parent/Guardia(s) Information

Name _____ Relation _____

Phone _____ Home _____ Cell

Name _____ Relation _____

Phone _____ Home _____ Cell

School Information

School Name _____ State _____

Local Advisor _____

Phone _____ Work _____ Cell

Medical Provider

Physician Name _____ Phone _____

Address _____

Is the individual covered by group or medical insurance: Yes No

Name of Insured _____

Insurance Company _____

Group Number _____ Policy Number _____

Please completely describe any medical condition which may recur or be a factor in medical treatment:

a. Allergies _____
b. Physical Handicap _____
c. Convulsions _____
d. Medicine Reactions _____
e. Blackouts _____
f. Disease of any kind _____
g. Heart/lung issues _____
h. Other (Be specific) _____

If currently taking medication, please provide the following information:

Name of medication _____

Prescribing Physician/Phone Number _____

LIABILITY RELEASE. I certify that the information on this form is accurate and complete to the best of my knowledge. I understand each individual is responsible for his/her own insurance coverage during this trip. I hereby release the HOSA Board of Directors, the HOSA Staff, State and Local HOSA Associations, and any designated individual in charge of the HOSA group or specific activity from any legal or financial responsibility with respect to my personal or my student/child's participation in or contact with any known element associated with an activity including competitive events.

PARENT/GUARDIAN: Please check one of the following and sign your name.

I give my permission for immediate medical treatment as required in the judgment of the attending physician. Notify me and/or any persons listed above as soon as possible.

I do not give permission for medical treatment until I have been contacted.

Parent/Guardian's Signature _____ Date _____
(Applicable for delegates under the age of 18 and must be signed by the parent or legal guardian.)

Delegate's Signature _____ Date _____

Advisor's Signature _____ Date _____